CHAPTER V: OUTPATIENT PPS PAYMENT CALCULATIONS

OBJECTIVES

The objective of this chapter is to provide participants with an understanding of the outpatient prospective payment system payment provisions. At the end of this session, participants will obtain an understanding of:

- The computation of provider specific APC payment rates using the national APC payment rates published in the *Federal Register*
- The application of applicable deductible and coinsurance amounts
- The provider's option to elect reduced copayments for specific APCs
- Pass-through, outlier and transitional corridor payments

APC PAYMENT RATE TABLE

Payment for services under the outpatient PPS system is calculated based on grouping outpatient services into ambulatory payment classification (APC) groups. The payment rates and coinsurance amounts calculated for an APC apply to all of the services within the APC. A hospital may bill for a number of APC payments furnished to an individual patient on a single day. However, if multiple surgical procedures are furnished to a patient in a single day, the APC payments are subject to discounting.

HCFA published a list of the outpatient APCs and unadjusted payment rates in the April 7, 2000, *Federal Register* as Addendum A, to the final rule.

A sample listing follows:

ADDENDUM A.—LIST OF HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0001	Photochemotherapy	S	0.47	$22.79	$8.49	$4.56
0002	Fine needle Biopsy/Aspiration	T	0.62	$30.06	$17.66	$6.01
0003	Bone Marrow Biopsy/Aspiration	T	0.98	$47.52	$27.99	$9.50
0004	Level I Needle Biopsy/Aspiration Except Bone Marrow	T	1.84	$89.22	$32.57	$17.84
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	5.41	$262.32	$119.75	$52.46
0006	Level I Incision & Drainage	T	2.00	$96.97	$33.95	$19.39
0007	Level II Incision & Drainage	T	3.68	$178.43	$72.03	$35.69
0008	Level III Incision & Drainage	T	6.15	$298.20	$113.67	$59.64
0009	Nail Procedures	T	0.74	$35.88	$9.63	$7.18
0010	Level I Destruction of Lesion	T	0.55	$26.67	$9.86	$5.33
0011	Level II Destruction of Lesion	T	2.72	$131.88	$50.01	$26.38
0012	Level I Debridement & Destruction	T	0.53	$25.70	$9.18	$5.14
0013	Level II Debridement & Destruction	T	0.91	$44.12	$17.66	$8.82
0014	Level III Debridement & Destruction	T	1.50	$72.73	$24.55	$14.55
0015	Level IV Debridement & Destruction	T	1.77	$85.82	$31.20	$17.16
0016	Level V Debridement & Destruction	T	3.53	$171.16	$74.67	$34.23
0017	Level VI Debridement & Destruction	T	12.45	$603.86	$289.16	$120.73
0018	Biopsy Skin, Subcutaneous Tissue or Mucous Membrane	T	0.94	$45.58	$17.66	$9.12
0019	Level I Excision/Biopsy	T	4.00	$193.95	$78.91	$38.79
0020	Level II Excision/Biopsy	T	6.51	$315.85	$130.53	$63.13
0021	Level III Excision/Biopsy	T	10.49	$508.83	$236.51	$101.73
0022	Level IV Excision/Biopsy	T	12.49	$605.80	$292.94	$121.12
0023	Exploration Penetrating Wound	T	1.98	$96.00	$40.37	$19.20
0024	Level I Skin Repair	T	2.43	$117.82	$44.50	$23.56
0025	Level II Skin Repair	T	3.74	$181.34	$70.66	$36.27
0026	Level III Skin Repair	T	12.11	$587.18	$277.92	$117.44
0027	Level IV Skin Repair	T	15.80	$766.10	$383.10	$153.22
0028	Incision/Excision Breast	T	12.85	$623.06	$303.50	$124.61
0030	Breast Reconstruction/Mastectomy	T	20.19	$978.95	$523.95	$195.79
0031	Hyperbaric Oxygen	S	3.00	$145.46	$140.85	$29.09
0032	Placement Transvenous Catheters/Arterial Cutdown	T	5.40	$261.83	$119.52	$52.37
0033	Partial Hospitalization	P	4.17	$202.19	$48.17	$40.44
0040	Arthrocentesis & Ligament/Tendon Injection	T	2.11	$102.31	$40.60	$20.46
0041	Arthroscopy	T	24.57	$1,191.33	$592.08	$238.27
0042	Arthroscopically-Aided Procedures	T	29.22	$1,416.79	$804.74	$283.36
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.64	$79.52	$25.46	$15.90

Column Descriptions for Addendum A

Column 1	APC Number
Column 2	APC Description
Column 3	The Status Indicator provides information on the type of service represented by the APC. • S – Represents significant APC procedures that are not subject to multiple procedural discounting. • T – Represents significant APC procedures that are subject to multiple procedural discounting. (Typically surgical procedures) • V – Represents medical visits billed on a per-visit basis • X – Represents ancillary services billed on a unit basis • P – Represents partial hospitalization services paid on a per-diem • F – Represents acquisition of corneal tissue paid at reasonable costs • G – Current drug/biological pass-through paid as an additional payment • H – Device pass-through paid as an additional payment • J – New drug/biological pass-through paid as an additional payment
Column 4	Relative weight used to compute unadjusted payment rate.
Column 5	Unadjusted payment rate for each APC. These amounts must be adjusted to reflect the wage index adjustment.
Column 6	National unadjusted coinsurance rate for each APC. These amounts were computed by HCFA using the median of the charges billed in 1996 for the services that constituted each APC group. The facility specific coinsurance amount for each APC will be computed by adjusting the amount in column 6 for wage index. The adjusted coinsurance amount for any hospital outpatient procedure cannot exceed the amount of the inpatient hospital deductible in a given payment year. The inpatient hospital deductible for calendar year 2000 is $776.00.
Column 7	Minimum unadjusted coinsurance amount for each APC. HCFA has determined that the coinsurance billed to beneficiaries be no lower than 20 percent of the APC payment made to the provider (with the exception of APCs relating to pass through items). The amounts in column 7 represent 20 percent of the APC payment amount in column 5. As with the APC payment amounts, the unadjusted minimum coinsurance amounts must be adjusted for wage index, to determine the provider's minimum coinsurance amount for each APC. As with the national adjusted coinsurance rates, the adjusted coinsurance amount for any hospital outpatient procedure cannot exceed the amount of the inpatient hospital deductible in a given payment year.

Sample Payment Computation

- **APCs 250, 258 and 343**
- **Has Not Met Deductible**
- **Hospital Wage Index 1.025**

Sample Payment Computation Data

To assist in understanding the payment concepts of the outpatient PPS system, we will work through the computations for a beneficiary that received the following services:

- Nasal Cauterization/Packing (APC 250)
- Tonsil/Adenoid Procedure (APC 258)
- Level II Pathology Services (APC 343)

The beneficiary has not met the $100 Part B deductible amount. The provider is located in a geographic location with a wage index of 1.025.

Outpatient Prospective Payment Calculation

- **Grouping of Outpatient Services into APCs**
- **Multiple APCs May be Billed on a Single Day (Discounting)**
- **Payment and Coinsurance Computed on an APC by APC Basis**

CALCULATION OF ADJUSTED APC PAYMENT AMOUNTS

Payment for services under the outpatient PPS system is calculated based on grouping outpatient services into ambulatory payment classification (APC) groups. The payment rates and coinsurance amounts calculated for an APC apply to all of the services within the APC. A hospital may bill for a number of APC payments furnished to an individual patient on a single day. However, if multiple surgical procedures are furnished to a patient in a single day, the APC payments are subject to discounting.

The calculation of the outpatient PPS payment amounts is computed on an APC by APC basis. The sample beneficiary data represents multiple services provided in the same day. The first step in calculating the adjusted APC payment amount will be identifying the status indicator, relative weight and unadjusted payment rate for each APC.

Identification of Payment Rates

APC	Status Indicator	Relative Weight	Payment Rate
250	T	2.21	$107.16
258	T	18.62	$902.83
343	X	.45	$21.82

Discounting

- **"T" – Surgical Procedures Subject to Discounting**
- **APC With Highest Weight Paid at 100%**
- **Discounting Will Be Applied to Coinsurance**
- **"X" – Ancillary Service Not Subject to Discounting**
- **Discounting for Terminated Surgical Procedure**

Discounting

Status indicator "T" identifies those surgical procedures that are subject to discounting. The full APC amount is computed for the surgical procedure with the highest weight. 50 percent of the APC amount is computed for any other surgical procedures performed at the same time.

In our example APC 258 will be computed at the full amount with APC 250 computed at 50 percent. As APC 343 represents an ancillary service, it is not subject to discounting.

APC	Payment Rate	Discount	Discounted Payment
258	$902.83	None	$902.83
250	$107.16	50%	$53.58
343	$21.82	None	$21.82

Similar discounting will occur where a surgical procedure terminates after a patient is prepared for surgery but before induction of anesthesia. Coinsurance amounts will be subject to any applicable discounting.

Packaging

The APC payments have been developed to include certain packaged items, such as anesthesia, supplies, certain drugs and the use of recovery and observation rooms. Initially the use of packaging is minimal. For example, ancillary services such as laboratory tests

and x-rays are not included in the specific APC payments. Payment for any services

excluded from OPPS will be made in addition to the OPPS payment for a surgical procedure or medical visit performed on the same day.

Geographic Adjustment

- **Hospital PPS Wage Index**
- **Labor Percentage 60%**

Payment Adjustment for Geographic Location

Adjustments for differences in wages across geographic areas will be made using the inpatient hospital PPS wage index. The hospital wage index in effect on October 1, will be the amount used to adjust payments for wage variances in the following calendar year for outpatient PPS. In computing the national APC rates HCFA estimated that 60 percent of the APC payment represented labor-related costs and therefore will be subject to the geographic adjustment.

In computing an APC payment for a particular provider, the APC payment will first be split between the labor and non-labor portions. Next the wage index factor will be applied to the labor-portion of the APC payment. Finally the non-labor portion of the APC payment will be added to the adjusted labor-portion of the payment.

Calculation of Geographic Location Adjustment

	APC 258	APC 250	APC 343
1) APC Payment Rate	$902.83	$53.58 Discounted	$21.82
2) Labor Percentage	.60	.60	.60
3) Labor Portion	$541.70	$32.15	$13.09
4) Non-Labor-Portion (1-3)	$361.13	$21.43	$8.73
5) Wage Adjusted Labor-Portion (3 x 1.025)	$555.24	$32.95	$13.42
6) Adjusted APC Payment (4+5)	$916.37	$54.38	$22.15

Deductible Amount

- **First $100 in Part B Payments Each Year**
- **Applied to APC With Highest Coinsurance First**

Deductible Amount

Beneficiaries are responsible for the first $100 in Part B payments each year. The deductible amount will be applied to the APC item with the highest coinsurance as a percent of the APC payment (or lowest program payment percentage as discussed below) and so on until the deductible is met or no other payments can be used to satisfy the deductible. This method is the most advantageous for the beneficiary.

The deductible computation does not apply to influenza virus vaccines, pneumococcal pneumonia vaccine and screening pelvic examinations.

In our example, the $100 deductible amount would be applied to the payment for APC 343 first, followed by APC 258.

Program Payment Percentage

- **Used to Apply Coinsurance**

Program Payment Percentage

In order to apply proper coinsurance amounts to the APC payments, HCFA will compute a "program payment percentage" for each APC. To determine the program payment percentage for each APC group, subtract the APC unadjusted copayment amount from the payment rate set for the APC group. Next divide the resulting difference by the APC payment rate, and multiply by 100. Using our sample data, the applicable program payment percentages are computed as follows:

Computation of Program Payment Percentage

	APC 258	APC 250	APC 343
1) APC Payment Rate	$902.83	$107.16	$21.82
2) APC Unadjusted Coinsurance	$462.81	$38.54	$12.16
3) Difference	$440.02	$68.62	$9.66
4) Line 3/Line 1	.4874	.6404	.4427
5) Payment Percentage (Line 4 x 100)	48.74%	64.04%	44.27%
6) Coinsurance Percentage	51.26%	35.96%	55.73%

Coinsurance Calculation

Adjusted APC Payment Rate

Less

Unmet Deductible

Less

Preliminary Medicare Payment Amount

Cannot Exceed Annual Inpatient Hospital Deductible Amount

Coinsurance Calculations

A coinsurance amount is calculated for each APC group. The copayment amount calculated for an APC group applies to all the services that are classified within the APC group. The beneficiary coinsurance amount for an APC is calculated as follows:

Subtract the APC group's Medicare payment amount from the adjusted APC group payment rate less any unmet deductible. For example, coinsurance amount = (adjusted APC group payment rate less any unmet deductible) - APC group preliminary Medicare payment amount. If the resulting amount does not exceed the annual hospital inpatient deductible amount for the calendar year, the resulting amount is the beneficiary coinsurance amount. If the resulting amount exceeds the annual inpatient hospital deductible amount, the beneficiary coinsurance amount is limited to the inpatient hospital deductible but the Medicare program pays the difference. The annual inpatient hospital deductible amount ($776 in CY 2000) is not adjusted for wage variances. Using our sample data, the applicable program payment percentages are computed as follows:

Calculation of Coinsurance Amount

	APC 343	APC 258	APC 250
1) Adjusted APC Payment Rate	$ 22.15	$916.37	$ 54.38 Discounted
2) Subtract Applicable Deductible	$22.15	$77.85	
3) APC Payment less Deductible	$ -0-	$838.52	$ 54.38
4) Program Payment Percentage	44.27%	48.74%	64.04%
5) Prelim. Medicare Payment Amount (Line 3 x Line 4)	$ -0-	$408.69	$ 34.82
6) Coinsurance Amount (Line 3 – Line 5)	$ -0-	$429.83	$ 19.56

Beneficiary pays a total of $449.39 in coinsurance and $100 in deductible. Program payments to provider equal $443.51, for total payments to provider of $ 992.90.

NOTE REGARDING APPLICATION OF DEDUCTIBLE AMOUNTS

It was previously noted that the deductible amount is be applied to the APC item with the highest coinsurance as a percent of the APC payment and so on until the deductible is met or no other payments can be used to satisfy the deductible. This method is used as it is the most advantageous for the beneficiary. The calculation below applies the deductible amount to the APC item with the lowest coinsurance amount as a percent of the APC payment first. This example is only being used to demonstrate the advantage to the beneficiary.

	APC 250	APC 258	APC 343
1) Adjusted APC Payment Rate	$ 54.38 Discounted	$916.37	$ 22.15
2) Subtract Applicable Deductible	$ -54.38	$ -45.62	$ -0-
3) APC Payment less Deductible	$ -0-	$870.75	$ 22.15
4) Program Payment Percentage	64.04%	48.74%	44.27%
5) Prelim. Medicare Payment Amount (Line 3 x Line 4)	$ -0-	$424.40	$ 9.81
6) Coinsurance Amount (Line 3 – Line 5)	$ -0-	$446.35	$ 12.34

Beneficiary pays a total of $458.69 in coinsurance and $100 in deductible. Program payments to provider equal $ 434.21, for total payments to provider of $ 992.90.

ELECTION TO OFFER REDUCED COPAYMENT AMOUNTS

Background

Maximum Copayment Based on 96 Charges

Minimum Copayment 20% of APC Rate

Under OPPS a hospital's billed copayment must fall between a minimum standard copayment amount (20 percent of the APC payment rate) and the standard national copayment amount (based on 20 percent of the wage-neutralized median charges billed in 1996, trended forward to 1999, for each APC group). As a general rule coinsurance cannot be less than 20 percent of the national payment rate. However, coinsurance on pass-through drugs is assessed on only a portion of the payment rate and as a result, will not necessarily equal 20 percent of the payment rate.

The maximum national copayment amount for an APC remains frozen, while the payment rate for the APC is increased by adjustments based on the Medicare market basket. As the APC rate increases and the maximum copayment amount remains frozen, the unadjusted coinsurance amount will eventually become 20 percent of the payment rate for all APC groups.

Transition to Standard Medicare Copayment Rate Gradual

Option to Reduce Coinsurance

For most APCs, the transition to the standard Medicare copayment rate will be gradual. For those APC groups for which copayment is currently a relatively high proportion of the total payment, the process will be correspondingly lengthy. As a result, the OPPS Final Regulations provide hospitals the option of electing to reduce copayment amounts and permit the hospitals to disseminate information on their reduced rates.

Notification of Election

Election Prior to Payment Year

- **Specific APC Groups**
- **Identify Copayment Amount**
- **In Effect Full Payment Year**
- **No Reduction to Individual Services Within APC**

Hospitals, before the beginning of a payment year, may elect to reduce the copayment amount otherwise established for some or all hospital outpatient services. Providers must notify their fiscal intermediary in writing of their election to reduce copayments no later June 1, 2000 for the period beginning July 1, 2000 and ending Dec. 31, 2000. For subsequent calendar periods the notice must be received 30 days prior to the start of that year. The notification must specifically identify the APC groups to which the provider's election will apply and the copayment level that the provider has selected for each group. The election of reduced copayment must remain in effect and unchanged during the year for which the election is made. A separate election must be made for each payment year.

A hospital may elect to reduce the copayment amount for any or all APC groups. A provider may **not** elect to reduce the copayment amount for some, but not all, services within the same APC group. A copayment amount for an APC group that is less than 20 percent of the adjusted APC payment rate may not be elected.

Hospital Advised to Study Impact of Coinsurance Election

Some Services Excluded From Election

No Reduction May be Reported as Bad Debt

In determining whether to make an election, hospitals should note that the national copayment amount under this system, based on 20 percent of national median charges for each APC, may yield copayment amounts that are significantly higher or lower than the copayment that the provider previously has collected. This is because the median of the national charges for an APC group, from which the copayment amount is ultimately derived, may be higher or lower than the provider's historic charges. Therefore, in determining whether to elect lower copayment and the level at which to make the election, it is advised that providers carefully study the wage-adjusted copayment amounts for each APC group in relation to the copayment amount that the provider has previously collected.

Providers may not elect to reduce copayments for screening sigmoidoscopies, screening colonoscopies,

or screening barium enemas. Coinsurance amounts for screening colonoscopes and sigmoidoscopes will be computed as 25% of the payment amount. The coinsurance amount for screening barium enemas is calculated at 20 percent of the APC payment rate. This copayment election also does not apply to vaccines provided by a CORF, vaccines, splints, casts and antigens provided by HHAs or splints, casts and antigens provided to a hospice patient for the treatment of a non-terminal illness.

No reduction in copayments elected by the hospital may be treated as bad debts.

Fiscal Intermediary Processing

Fiscal Intermediary Processing

- **Notify Provider of Receipt**
- **Validate Coinsurance Amounts**
- **Amounts Entered into Provider File**

HCFA issued Program Memorandum Number A-00-36, addressing the election of reduced copayments and provided a suggested format for the submission of the provider notification. Intermediaries are to send an acknowledgement to the hospitals that their election notice has been received within 15 calendar days of the receipt.

Fiscal intermediaries will be required to validate that the elected copayment amounts do not exceed the adjusted national copayment amounts or the inpatient deductible for the year of the election (In calendar year 2000, the inpatient deducible amount is $776). Elected copayment amounts must equal to or exceed 20 percent of the adjusted APC payment rate. In addition, the validated copayment amounts must be entered into the provider file prior to the processing of claims for the payment year.

Sample Calculation of Maximum And Minimum Copayment Amounts

APC 258 – Tonsil/Adenoid
Unadjusted Payment Rate - $902.83
National Unadjusted Coinsurance - $462.81
Minimum Unadjusted Coinsurance - $ 180.57
Wage index 1.025

Unadjusted Payment Rate	$902.83
Wage Related Percentage	60%
Wage Related Portion	541.70
Wage Index	1.025
Wage Related Payment	555.24
Non-Wage Related Portion ($902.83 x 40%)	361.13
Adjusted Payment Rate	916.37
Adjusted Minimum Copayment Amount (20% Adjusted Payment Rate)	**183.27**
Unadjusted National Coinsurance	$462.81
Wage Related Percentage	60%
Wage Related Portion	277.69
Wage Index	1.025
Wage Related Payment	284.63
Non-Wage Related Portion ($462.81 x 40%)	185.12
Adjusted Maximum Copayment Amount	**469.75**

Provider may elect a reduced copayment amount between **$183.27** and **$469.75**.

Sample Payment Calculation with Reduced Coinsurance

Using the previous example, we will re-compute the facility and beneficiary payment amounts, assuming that the provider elected a copayment amount of $200, for APC number 258.

Step One – Wage Index Adjustment

	APC 258
1) APC Payment Rate	$902.83
2) Labor Percentage	.60
3) Labor Portion	$541.70
4) Non-Labor-Portion (1-3)	$361.13
5) Wage Adjusted Labor- Portion (3 x 1.025)	$555.24
6) Adjusted APC Payment (4+5)	$916.37

Step Two – Calculation of Program Payment Percentage

	APC 258
1) APC Payment Rate	$902.83
2) APC Unadjusted Coinsurance	$462.81
3) Difference	$440.02
4) Line 3/Line 1	.4874
5) Payment Percentage (4 x 100)	48.74%

Step Three- Calculation of Preliminary Medicare Payment Amount and Total Payment to Provider

	APC 258
1) Adjusted APC Payment Rate	$916.37
2) Subtract Applicable Deductible	$100.00
3) APC Payment less Deductible	$816.37
4) Program Payment Percentage	48.74%
5) Prelim. Medicare Payment Amount (3 x 4)	$397.90
6) Adjusted Coinsurance Amount (line 3 – line 5=$418.47, but elected $200.00)	$200.00

Calculation of Total Payments

7) Total Beneficiary Payments to Provider (2 + 6)	$300.00
8) Total Program Payments to Provider (line 5)	$397.90
9) **Total Payments to Provider**	**$697.90**

Calculation of Total Payments
With No Election

10) Total Beneficiary Payments to Provider (2 +$418.47)	$518.47
11) Total Program Payments to Provider (line 5)	$397.90
12) **Total Payments to Provider**	**$916.37**

Payment for New Technologies

- **New Technological Service APCs**
- **New Services That Cannot be Placed in Existing APCs will be Assigned to New APCs**
- **APC Groups 970-984, Based on Cost of Services**

PAYMENT FOR NEW TECHNOLOGIES

Special APC groups have been created to accommodate payment for new technology services. These new APC groups do not take into account clinical aspects of the services they are to contain, but only their costs. HCFA will assign new items and services that cannot be appropriately placed in existing APC groups for established procedures and services to the new technology APC groups.

The final APC groups for new technology are groups 970 through 984 and cover a range of costs from less than $50 to $6,000. Upon implementation of OPPS, the following new technology services will be paid under the designated APC groups.

HCPCS	
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy
53852	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy
96570	Photodynamic therapy, first 30 minutes
96751	Photodynamic therapy, each additional 15 minutes
G0125	PET lung imaging of solitary pulmonary nodules, using 2-(Fluorine-18)-Fluoro-2-Deoxy-D-Glucose (FDG), following CT (71250/71260 or 71270)
G0126	PET lung imaging of solitary pulmonary nodules, using 2-(Fluorine-18)-Fluoro-2-Deoxy-D-Glucose (FDG), following CT (71250/71260 or 71270); initial staging of pathologically diagnosed non-small cell lung cancer
G0163	Positron emission tomography (PET), whole body, for recurrence of colorectal metastatic cancer
G0164	Positron emission tomography (PET), whole body, for staging and characterization of lymphoma
G0165	Positron emission tomography (PET), whole body, for recurrence of melanoma or melanoma metastatic cancer
G0168	Wound closure by adhesive
G0166	External counterpulsation, per treatment session

When Cost Data Obtained

- **Move to Clinical APC**
- **Or Create New APC**

After HCFA gains information about actual hospital costs incurred to furnish a new technology service, they will move it to a clinically related APC group with comparable resource costs. If they cannot move the service to an existing APC, a separate APC will be established.

Services Identified as New Technology

- **At Least 2 Years But Not More Than 3 Years**
- **Annual Updates to APC Groups**
- **Coinsurance Based on 20% of Payment Rate**

HCFA will retain a service within a new technology APC group for at least 2 years, but no more than 3 years, consistent with the time duration allowed for the transitional pass-through payments. Movement from a new technology APC to a clinically related APC would occur as part of the annual update of APC groups.

As historical charge data are not available for new technology services, beneficiary coinsurance amounts in the new technology APC groups are 20 percent of the payment rates.

TRANSITIONAL PASS-THROUGHS FOR INNOVATIVE MEDICAL DEVICES, DRUGS AND BIOLOGICALS

BBRA-97 Required Transitional Pass-Through Payments for Innovative Medical Drugs and Biologicals

- **"Current"**
- **"New"**

HCFA is required by the BBRA-99 to make additional payments to hospitals for a period of 2 to 3 years for specific items. The items specified by the law are the following:

- Current orphan drugs
- Current drugs, biologic agents and brachytherapy devices used for the treatment of cancer
- Current radiopharmaceutical drugs and biological products
- New medical devices, drugs and biologic agents, in instances where the item was not being paid for as hospital outpatient services as of Dec. 31, 1996, and where the cost of the item is "not insignificant" in relation to the hospital outpatient PPS payment amount.

The term "current" refers to those items for which hospital outpatient payment is being made on the first date OPPS is implemented.

The term "new" refers to products that were not being paid for as hospital outpatient services as of Dec. 31, 1996, and where the cost of the item is "not significant" in relation to the hospital outpatient PPS payment amount.

Current Designated Drugs and Biologicals

- **95% of Average Wholesale Price**
- **Addendum K to Final Rule**

New Drugs and Biologicals

- **Assign New APCs**
- **95% of Average Wholesale Price**
- **Criteria For Designation in Final Rule**

New Devises

- **Assign New APCs**
- **Reasonable Cost of New Devise Reduced by Amount Included in APC**

The current designated drugs and biologicals will be assigned to special APCs and identified by the OCE as eligible for payment at 95 percent of the average wholesale price. Current designated drugs and biologicals have been identified in Addendum K of the final rule.

New designated drugs and biologicals may be approved for payment and their payment will be calculated in the same manner as listed above for current designated drugs and biologicals. Criteria for designating new drugs or biologicals have been published in the final rule.

As new devices are designated, APCs will be assigned as eligible for payment based on the reasonable cost of the new device, reduced by the amount included in the APC for the procedure that reflects payment for the old device. Before January 1, 2002, charges for devices eligible for pass-through will be adjusted to costs on each claim by applying the individual hospital's average cost-to-charge ratio across all outpatient departments. Although HCFA plans to reduce the device pass through payment by the amount of related device costs in the APC, the analysis to identify that amount will not be completed in time for the implementation date.

The total amount of pass-through payments in any calendar year cannot be projected to exceed the following percentages of total OPPS payments:

- For a year or portion of a year before 2004, 2.5 percent.

- For subsequent years 2 percent.

If HCFA estimates that total pass-through payments would exceed the caps, additional payments would be

reduced uniformly to ensure that the cap is not exceeded.

OUTLIER ADJUSTMENTS

PRICER will calculate outlier payments on a claim-by-claim basis. The outlier payment will be calculated by:

- Calculating the costs related to the OPPS services on the claim by multiplying the total charges for covered OPPS services by an outpatient cost-to-charge ratio;

- Determining whether these costs exceed 2.5 times the OPPS payments (APC payments plus any transitional pass-through amounts for drugs, biologicals and/or devices) for the claim; and

- If costs exceed 2.5 times the OPPS payments, the outlier payment is calculated as 75 percent of the amount by which the costs exceed 2.5 times the OPPS payments.

Sample Outlier Computation

To assist in understanding the outlier payment concept, we will work through a computation for a sample provider. Required data includes:

- Total Charges for all Covered Services - $3,000
- Outpatient Cost to Charge Ratio – 0.987564
- Total OPPS Payments on Claim- $992.90

1) Total Charges for all Covered OPPS Services on Bill	$3,000.00
2) Outpatient Cost to Charge Ratio	0.987564
3) Computed Costs for OPPS Services	$2962.69
4) Total OPPS Payments on Claim	$992.90
5) OPPS Outlier Threshold (Line 4 x 2.5)	$2482.25
6) Amount of Costs Over Threshold (Line 3 – Line 5)	$480.44

7) Outlier Payment (Line 6 x .75)	$**360.33**

TRANSITIONAL OUTPATIENT PAYMENTS (TOP)

Background

Transitional Payments to Prevent Significant Losses in Payments Under PPS

BBRA-99, Section 202, establishes transitional corridors for the first three and a half years of the OPPS to ensure that providers do not experience a significant loss in payments under the PPS. HCFA will establish a formula to compute additional Medicare payments if the amount received under OPPS in relation to costs is less than the payment-to-cost ratio in 1996. The 1996 payment-to-cost ratio will be calculated as if the formula driven overpayments were eliminated in 1996. These transitional payments will have no effect on beneficiary copayments.

In order to determine transitional payments, a comparison is made between a provider's payments (including cost-sharing) under the prospective payment system in a given year (the PPS amount) and the hospital's costs in that year multiplied by the hospital's 1996 payment to cost ratio (the pre-BBA amount).

For services furnished prior to January 1, 2002, if the provider's PPS amount is:

- Between 90% and 100% of the pre-BBA amount, 80% of that loss will be made up by additional Medicare payments.
- Between 80% and 90% of the pre-BBA amount, the hospital will receive additional payments equal to the amount by which 71% of the pre-BBA amount exceeds 70% of the PPS amount.
- Between 70% and 80% of the pre-BBA amount, the hospital will receive additional payments equal to the amount by which 63% of the pre-BBA amount exceeds 60% of the PPS amount.
- Less than 70% of the pre-BBA amount, the hospital will receive additional payments equal to 21% of the pre-BBA amount.

In 2002, if the provider's PPS amount is:

- Between 90% and 100% of the pre-BBA amount, 70% of that loss will be made up by additional Medicare payments.
- Between 80% and 90% of the pre-BBA amount, the hospital will receive additional payments equal to the amount by which 61% of the pre-BBA amount exceeds 60% of the PPS amount.
- Less than 80% of the pre-BBA amount, the hospital will receive additional payments equal to 13% of the pre-BBA amount.

In 2003, if the provider's PPS amount is:

- Between 90% and 100% of the pre-BBA amount, 60% of that loss will be made up by additional Medicare payments.
- Less than 90% of the pre-BBA amount, the hospital will receive additional payments equal to 6% of the pre-BBA amount.

Full Pre-PPS Amount for Some Rural and Cancer Hospitals

If a hospital is located in a rural area with not more than 100 beds, Medicare payments shall be increased to that hospital to ensure that its PPS amount is no lower than its pre-BBA amount for each year before 2004.

In the case of cancer hospitals, Medicare payments shall be increased to ensure that their PPS amount in each year is no lower than their pre-BBA amount.

HCFA will make additional transitional payments to providers under this provision on an interim basis, subject to retrospective adjustments based on settled cost reports.

Interim Payment Calculations

HCFA issued Program Memorandum A-00-36 providing instructions to fiscal intermediaries regarding the computation of interim payments for the transitional corridor. Intermediaries are to begin calculation of

interim corridor payments on September 1, 2000. Interim payments are to be computed on a monthly basis, with payment made prior to the beginning of the next month. For example, beginning September 1, 2000, a payment determination will be made for the period 8/1/2000 through 7/30/2000. Any applicable payment is to be made prior to October 1, 2000.

While HCFA has determined the statistics required to make the interim payments, system changes to obtain all the required statistics have not yet been identified. The following statistics will be required:

- Provider Number
- Fiscal Year Begin Date
- Provider Type (Cancer/non-Cancer)
- Change Code for Wage index Reclassification
- Actual Geographic Location-MSA (Urban/Rural)
- Wage index Location - MSA
- Bed Size (Over 100 Beds)
- Outpatient Cost-to-Charge Ratio (Determined by HCFA)
- Total Charges for all Covered Services
- Total OPPS Payments
- Total Unreduced Coinsurance Amounts
- Total Deductible Amounts
- Payment-to-cost ratio (Determined by HCFA from the hospital's 1996 Medicare revenues and costs.)

For interim payment purposes, the pre-BBA amount will be computed using the following methodology. Outpatient service costs will be calculated by applying an outpatient cost-to-charge ratio, developed by the HCFA, to total outpatient charges for the period. A payment-to-cost ratio of 80%, will be applied to costs for the interim payment calculation.

Computed outpatient costs, adjusted by the payment to cost ratio, will be compared to total payments made under OPPS during the period, to determine if a transitional corridor payment is to be made.

All computed transitional corridor payments will be reduced by an additional 15% for interim payment purposes.

Sample calculations of transitional corridor payments follow.

Sample TOP Calculation

To assist in understanding the TOP payment concept, we will work through a computation for a sample provider. Required data includes:

- Outpatient Cost-to-Charge Ratio – 0.987564
- Total Charges for all Covered Services - $125,000
- Total OPPS Payments - $90,000

All the data used in this example is hypothetical.

The outpatient cost-to-charge ratio will be provided by HCFA. Total charges and total OPPS payments will be provided by the claims systems. Total payments include OPPS program payments made to the provider (including outlier and transitional pass-through payments) and related OPPS payments made to the provider by the beneficiary. While providers may reduce beneficiary payments through the election of reduced coinsurance amounts, unreduced coinsurance amounts will be used in the TOP calculation.

Step 1: Compute Pre-BBA Amount

Total charges relating to covered services for all OPPS services will be identified. These charges will then be converted to cost by multiplying them by an outpatient cost to charge ratio provided by HCFA. For interim payment purposes, a payment-to-cost ratio of 0.8 will be applied to the computed costs.

Computation of Pre-BBA Amount	
1) Total Charges for all covered OPPS covered services	$125,000
2) Outpatient Cost to Charge Ratio	0.987564
3) Total Costs for OPPS Services (Line 1 x Line 2)	$123,446
4) Payment to Cost Ratio	0.80

5) Pre-BBA Amount (Line 3 x Line 4)	**$98,757**

Step 2: Comparison of OPPS Pre-BBA Amount to OPPS Payments

Total Medicare payments, including unreduced coinsurance, deductible, outlier and transitional pass-through amounts, are compared to the pre-BBA amount computed in step 1.

Comparison to Pre-BBA Amount	
1) Total OPPS Program Payments	$90,000
2) Pre-BBA Amount From Step 1	$98,757
3) Amount by which costs adjusted by the payment-to-cost ratio, exceeds OPPS Payments	**$8,757**

If the amount computed in step 2 is less than or equal to zero, no transitional payment will be made for the month. However, the total program payments and pre-BBA amounts will be carried-forward to the next month's computation. No carry-forward will occur on the last month of the provider's fiscal year, as final settlement will occur on the cost report.

Step 3: Computation of OPPS Amount as a Percentage of Pre-BBA Amount

Divide the total OPPS Program payments by the Pre-BBA amount computed in step 1.

Computation of OPPS Amount as a Percentage of Pre-BBA Amount	
1) Total OPPS Program Payments	$90,000
2) Pre-BBA Amount From Step 1	$98,757
3) OPPS Payment to Pre-BBA Cost Ratio	**.91**

In this example total OPPS Program payments represent 91% of OPPS costs.

Step 4: Computation of Monthly TOP Payment Amount – Prior to January 1, 2002

Computation of Monthly TOP Payment Amount (Only One Computation Will Apply)	
If the Hospital is a small rural hospital with less than 101 beds or a cancer hospital, pay 85 percent of the amount computed in step 2. *(If small rural hospital 8,757 x .85 = $7,443)	$7,443 *
If the result of step 3 is greater than or equal to .9 and less than 1.0, multiply the amount computed in step 2 by .8, then pay 85 percent of the result. **(If not a small rural hospital [8,757 x .8] x .85 = $5,955)	$5,955**
If the result of step 3 is greater than or equal to .8 and less than .90, the TOP payment will be computed as the amount by which 71% of the pre-BBA amount computed in step 1 exceeds 70% of the total OPPS payments identified in step 2. For interim payment purposes, 85% of this amount will be paid.	
If the result of step 3 is greater than or equal to .7 and less than .8, the TOP payment will be computed as the amount by which 73% of the pre-BBA amount computed in step 1 exceeds 60% of the total OPPS payments identified in step 2. For interim payment purposes, 85% of this amount will be paid.	
If the result of step 3 is less than .7, the TOP payment will be computed as 21% of the pre-BBA amount identified in step 1. For interim payment purposes 85% of this amount will be paid.	

Final Settlement of TOP Payments

- **Document Monthly Calculations**
- **Year End Settlement on Cost Report**

Final Settlement

Fiscal intermediaries must maintain documentation for monthly calculations and payments made for the transitional corridor provision. Final settlement will be calculated at year-end using actual payment and cost data. The hospital cost report is currently being revised

OPPS PRICER

Outpatient Pricer determines the amount to pay as well as deductions for deductible and coinsurance.

This HCFA-developed software determines the APC line item price based on data from the OPROV specific file, your beneficiary deductible record and the OCE output file. The software will output a data record with the following information:

- All information passed from OCE;
- The APC line item payment amount;
- The APC line item deductible;
- The APC line item coinsurance amount;
- The total deductible applied to the OPPS services on the claim;
- The total outlier amount for the claim to be paid in addition to line item APC payments and to be output to CWF via value code 17, same as the current process for inpatient outlier payments;
- The partial hospitalization payment amount if applicable; and
- A Pricer assigned review code to indicate why/how Pricer rejected or paid the claim.

Four Additional Fields Added to Electronic remittance Advice:

- **APC Allowed Amount**
- **APC Number**
- **Partial Hospitalization Per Diem**
- **Outlier Amount**
- **Transitional Outpatient Payments**

ELECTRONIC REMITTANCE ADVICE

The electronic remittance advice (version 3051.4A.01) is equipped to report data at a summary level on a line item basis. Once CELIP has been implemented the electronic remittance advice will report line level data. As a result, it was only necessary to include the following data for OPPS:

APC Allowed Amount	The determined payable for an OPPS service whether APC or AWP.
APC Number	The APC assigned to HCPCS code.
Partial Hospitalization Per diem	The partial hospitalization per diem amount determined by OPPS Pricer. This amount will be reported on claim level
Outlier Amount	The outlier amount determined on per-claim basis by OPPS Pricer.
Transitional Outpatient Payments (TOPs)	The transitional outpatient payment determined on a monthly basis by the intermediary's claims processing system. This amount will be reported on a provider level.

Transitional Outpatient Payments Field Added to Standard Paper Remittance Advice

STANDARD PAPER REMITTANCE ADVICE

The standard paper remittance advice has been updated to reflect a new field for transitional outpatient payments. No additional fields have been added for OPPS

For Services Occurring On Or After July 1, 2000:

- **New OPPS PS&R Detail and Summary Reports Will Be Produced**
- **Outpatient ASC, Radiology and Other Diagnostic PS&R Reports Will Be Eliminated**

PROVIDER STATISTICAL AND REIMBURSEMENT (PS&R) REPORT

The following fields have been tentatively approved for the new OPPS PS&R report for services paid under OPPS:

HCPCS procedure code	The HCPCS procedure code on the claim.
APC	The APC that OPPS Pricer used to determine payment.
APC Payment	The line item APC payment amount determined by OPPS Pricer.
Service indicator/TOB	The service indicator and type of bill code determined by OCE: Following are valid service indicator codes: S- Significant procedure not subject to multiple procedure discounting T- Significant procedure subject to multiple procedure discounting V- Medical visit X- Ancillary service P- Partial hospitalization service N- Packaged incidental service A-Services not paid under OPPS C- Inpatient procedure E- Non-covered items or services F- Corneal tissue acquisition G- Designated current drug or biological H- Designated new device J- Designated new drug or new biological Following are valid TOB codes: 0-For type of bill the service is paid under OPPS 1-For type of bill the service is not paid under OPPS
Payment indicator	The payment indicator codes returned by OCE. Following is a list of valid payment indicator codes: 1- Paid standard OPPS amount (service

	indicators S, T, V, X, P) 2- Services not paid under OPPS (service indicator A, or no HCPCS code and certain revenue codes) 3- Not paid (service indicators C, E) 4- Acquisition cost paid (service indicator F) 5- Designated current drug or biological payment adjustment (service indicator G) 6- Designated new device payment adjustment (service indicator H) 7- Designated new drug or new biological payment adjustment (service indicator J) 8- Not used at present 9- No separate payment, payment included in line items with APCs (service indicator N, or no HCPCS code and certain revenue codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization program services))
Discounting factor	The discount factor calculated by the outpatient code editor.
Line item denial or rejection flag	The denial or rejection flag returned by OCE: Following is a list of valid denial or rejection flags: 0- Line item not denied or rejected 1- Line item denied or rejected (procedure edit return buffer for line item contains a 9, 13, 17, 19, 20, 21, 39, 40 or 42) 2- Line item is on a multiple day claim. The line is not denied or rejected, but occurs on a day that has been denied or rejected. (applicable for edit 18 only)
Packaging flag	The packaging flags returned by OCE: Following is a list of valid packaging flags: 0- Not packaged 1- Packaged service (service indicator N) 2- Packaged as part of partial hospitalization per diem or daily mental health service per diem
Payment adjustment flag	The payment adjustment flag returned by OCE: Following are valid payment adjustment flags: 0- No payment adjustment

	1- Designated current drug or biological payment adjustment applies to APC (service indicator G) 2- Designated new device payment adjustment applies to APC (service indicator H) 3- Designated new drug or new biological payment adjustment applies to APC (service indicator J) 4- Deductible not applicable (specific list of HCPCS codes)
Service Units	The number of service units. Note: For APCs 33 or 34, the service units are always assigned a value of one by the OCE even if the input service units were greater then one.
Charges	The charges on the claim.
Outliers	The outlier amount determined on a per-claim basis by OPPS Pricer.
Coinsurance Election	The reduced (waived) coinsurance election amount on a line item basis.
Partial Hospitalization	The payments made under the partial hospitalization program

Transition Outpatient Payments (TOPS) May Not Be Included in PSR Reports

Note: The transitional outpatient payment determined on a monthly basis by the intermediary's claims processing system may not be shown on the new PS&R reports for services paid under OPPS.

Blended Payments Eliminated

Outpatient ASC, outpatient radiology and outpatient other diagnostic services will no longer be reimbursed based on a blended rate for services provided on or after July 1, 2000. As a result, no data should appear on the PS&R reports for outpatient ASC, outpatient radiology or outpatient other diagnostic for services provided on or after July 1, 2000.